PRE-APPLICATION TO MEDICAL STAFF

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

All licensed independent practitioner applicants who are applying for the positions listed below, or the equivalent of those positions, must complete this form. **Fax the completed form, along with your CURRENT Curriculum Vitae and other requested documents, to the California Department of Corrections and Rehabilitation (CDCR) Credential Coordinator at (916) 324-6763.** If you have any questions, the agent may be reached by telephone at (916) 327-3336.

TO PREVENT UNNECESSARY DELAYS IN PROCESSING YOUR APPLICATION, PLEASE PRINT LEGIBLY AND PROVIDE ALL REQUESTED INFORMATION.

Application for the Position of: ☐ **Nurse Practitioner**

Name: Last: _____ First: _____ Middle: _____

Other Names Used: _____ Gender: ☐ Female ☐ Male

Full Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip Code

Contact Information: _____
e-mail address phone numbers

United States Citizen: ☐ Yes ☐ No. If no, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

If you hold permanent immigrant status in the U.S., please attach a copy of your green card or approval letter.

National Identification number: _____ Country of Issue _____

Professional school(s) (nursing or medical degrees):

Name	Degree	Year Graduated

Professional license(s)/certifications/registrations (medical, nurse practitioner, physician assistant):

License number: _____ State: _____ License number: _____ State: _____

License number: _____ State: _____ License number: _____ State: _____

License number: _____ State: _____ License number: _____ State: _____

Name of Specialty Residency _____

Board eligible: ☐ Yes ☐ No If Yes, name of Board: _____

Board certified: ☐ Yes ☐ No If Yes, Board: _____

Most recent year certified/recertified: _____

DEA Number: _____ Expiration Date: _____

BLS Certification: _____ Expiration Date: _____
(Please attach a copy the certificate to this application)

ANY AFFIRMATIVE ANSWER TO QUESTIONS ONE THROUGH 18 REQUIRES ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER, ELABORATING UPON THE RESPONSE AND DESCRIBING THE CIRCUMSTANCES INVOLVED.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? □ Yes □ No
2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? □ Yes □ No
3. Have you ever been asked to surrender your license? □ Yes □ No □

☐ Additional information is attached for the above section (questions ___, ____, ___)

---

4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, CHAMPUS, or Medicaid)? □ Yes □ No
5. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? □ Yes □ No
6. Has your federal or state narcotics registration certificate ever been relinquished, limited, denied, suspended, or revoked? □ Yes □ No
7. Is your federal or state narcotics registration certificate currently being challenged? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ___)

---

8. Have you ever been named as a defendant in any criminal proceedings? □ Yes □ No
9. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? □ Yes □ No
10. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? □ Yes □ No
11. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ____)

---

12. Have any profession liability claims or suits ever been filed against you or are any presently pending? □ Yes □ No
13. Have any judgments or settlements been made against you in professional liability cases? □ Yes □ No
14. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? □ Yes □ No
15. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___)

---

16. Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment, or supply house or other business to which patients from the CDCR might be referred or recommended?
17. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the Division of Correctional Health Care Services to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? □ Yes □ No
18. Did you change medical schools and/or residency programs? □ Yes □ No
19. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? □ Yes □ No
20. Have you ever been examined by any specialty board and failed to pass the examination? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___, ___)

FOR QUESTIONS 21, AND 22, PROVIDE ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER WHEN DIRECTED TO DO SO AS A RESULT OF YOUR ANSWER

21. If not currently certified, have you applied for: ☐ **Physician's Assistants**: National Certification? ☐ Yes ☐ No
☐ **Physicians**: Family Medicine or Internal Medicine: ☐ Yes ☐ No
☐ **Nurse Practitioners**: Adult or Family Medicine: ☐ Yes ☐ No.
If not, do you intend to apply for the relevant certification exam? ☐ Yes ☐ No.
If no, please explain why on a separate piece of paper. ☐ Additional information attached.

22. Have you been accepted to take the relevant certification exam? ☐ Yes ☐ No
If yes, what dates are/were you scheduled to take the certification exam?

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this pre-application, whether intentional or not, may constitute sufficient cause for rejection of this pre-application resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____

Signature of Applicant Date

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____

Effective from __/__/__ to __/__/__

Applicant: *Check off the "Requested" box for clinical privilege requested. New applicants may be requested to provide documentation of the number and types of cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Division of Correctional Health Care Services (DCHCS) for a proper evaluation of current competence, and other qualifications and for resolving any doubts.*

Professional Practices Executive Committee Chairperson (PPEC) or Designee: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Qualifications for Nurse Practitioner (NP)

Initial Applicant - To be eligible to apply for initial clinical privileges as a NP, the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency;

AND

Current active licensure to practice professional nursing in the State of California; and current active certification by the California Board of Registered Nursing as an advanced practice nurse in the nurse practitioner category, with specialization as an adult nurse practitioner, obstetrical-gynecological nurse practitioner, or family nurse practitioner,

AND

Current certification by the American Nurses Credentialing Center, the National Certification Corporation for Ob, Gyn, and Neonatal Nursing Specialists, or an equivalent body approved by the California Board of Registered Nursing, or be actively seeking certification and obtain the same on the first examination for which s/he is eligible, or successful completion of an examination as required by the DCHCS.

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the DCHCS GB or indemnification by the State of California,

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Special Services/Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training, and documentation of competence to obtain and maintain services as set forth in policies governing allied health professionals and the provision of specific services.

Supervision: The exercise of these specified services require a designated collaborating/supervising physician with clinical privileges at the Institution. All practice is performed under the supervision of this physician/designee and in accordance with written policies and protocols developed and approved by the Interdisciplinary Committee, PPEC, Nursing Administration and the DCHCS GB**.** The collaborating / supervising physician must be readily available to effectively supervise the NP on the performance of standardized procedure practices.

Categories of Patients Practitioner May Treat: May provide services consistent with the standardized procedures and the policies stated herein to California Department of Corrections and Rehabilitation (CDCR) inmate-patient population of the medical staff member(s) with whom the NP has a documented formal affiliation or to such inmate-patients as are assigned. NPs may not admit patients to the licensed inpatient setting.

Medical Record Charting Responsibilities: Clearly, legibly, completely, and in timely fashion, describe each service the NP provides to a patient in the Institution and relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made.

General Relationship to Others: NPs have authority to direct any institution health care personnel in the provision of clinical services to patients to the extent that such direction is necessary in order to carry out the services required by the patient and which the NP is authorized to provide.

Periodic Competence Assessment: Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the Institution's existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide in CDCR institutions. In addition, continuing education related to the specialty area of practice is recommended/required as mandated by licensure.

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

NURSE PRACTITIONER CLINICAL PRIVILEGES – PRIMARY CARE

❑ Requested

Adult inmate-patients within the inpatient and outpatient settings, except as specifically excluded from practice:

- Counsel and instruct patients and significant others as appropriate
- Debridement, suture, and general care for superficial wounds and minor superficial surgical procedures
- Incision and drainage of superficial abscesses
- Initiate referral to appropriate physician or other health care professional of problems that exceed the NP's scope of practice
- Local anesthetic techniques
- Make rounds on patients with, or at the direction of, the supervising physician
- Monitor and manage stable chronic illnesses of population served
- Obtain and record medical/social history and perform physical examination including rectal and pelvic examination as indicated
- Order diagnostic testing and therapeutic modalities such as medications, treatments, IV fluids and electrolytes, etc.
- Perform diagnosis and treatment as determined by established, written protocols between NP's scope of knowledge and training and the supervising/collaborating physician's scope of practice
- Perform primary health care maintenance of the population served
- Perform routine immunizations
- Start IV's
- Write discharge summaries

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Qualifications for NP Clinical Privileges – Obstetrics / Gynecology Care

To be eligible to apply for core privileges as a NP with clinical privileges in Obstetrics / Gynecology, the applicant must meet the following criteria:

Applicant must satisfy the qualification requirements for nurse practitioner,

AND

Documented training and experience in a NP program that included obstetrics/ gynecology as part of the curriculum and demonstrated current competence.

Periodic Competence Assessment: Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the institution's existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide at DCHCS Institutions. In addition, continuing education related to the specialty area of practice is recommended/required as mandated by licensure.

NURSE PRACTITIONER CLINICAL PRIVILEGES - OBSTETRICS / GYNECOLOGY
(Includes Nurse Practitioner Clinical Privileges -Primary Care)

☐ **Requested**

Provide services for female adult patients within the inpatient and outpatient settings, except as specifically excluded from practice that include the following:

- Care before and after menopause
- Contraceptive care
- Evaluation and treatment of common vaginal infections
- Health and wellness counseling
- Norplant removal
- Perform physical exams, including rectal exams and Pap smears
- Pregnancy testing and care before, during, and after pregnancy
- Screen and refer for other health problems including suspected sexual abuse, rape
- STD screen and follow up

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

SPECIAL NON-CORE PRIVILEGES (See Qualifications and/or Specific Criteria Below)

PRESCRIPTIVE AUTHORITY AS DELEGATED BY A PHYSICIAN IN A COLLABORATIVE PRACTICE AGREEMENT IN ACCORDANCE WITH STATE LAW

❒ Requested: DEA Schedules III, IV, V

Criteria: Completion of a California Board of Registered Nursing approved pharmacology course that included a minimum of 520 hours of physician supervised experience in furnishing drugs and/or devices, and current Furnishing Number from the State of California and DEA registration. The physician must be available by telephonic contact at the time of the patient examination by the nurse practitioner.

❒ Requested: DEA Schedule II

Criteria: Completion of a California Board of Registered Nursing approved pharmacology course that included a minimum of 520 hours of physician supervised experience in furnishing drugs and/or devices; and current Furnishing Number from the State of California, DEA registration; and evidence of completion of a course including Schedule II controlled substances based on the standards developed by the California Board of Registered Nursing. The physician must be available by telephonic contact at the time of the patient examination by the NP.

COLPOSCOPY

❒ Requested

Criteria: Documented training or experience to include colposcopy.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 colposcopy procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 colposcopy procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

ENDOMETRIAL BIOPSY

❒ Requested

Criteria: Documented training or experience to include endometrial biopsy.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 endometrial biopsy procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 endometrial biopsy procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

NURSE PRACTITIONER CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

ULTRASOUND FOR FETAL POSITIONING

❒ Requested

Criteria: Documented training or experience in ultrasound for fetal positioning.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 ultrasounds for fetal positioning procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 ultrasounds for fetal positioning procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the California Department of Corrections and Rehabilitation (CDCR), and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by CDCR, DCHCS, and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed:_____ **Date:**_____

PPEC Chairperson or Designee Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

❑**Recommend requested clinical privileges**

❑**Recommend clinical privileges with the following conditions/modifications:**

❑**Do not recommend the following requested clinical privileges:**

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

PPEC Chairperson or Designee Signature_____ **Date**_____

PPEC Chairperson or Designee Name (print)_____